DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing WI Statutes s. 49.47
HCF 10100A (Formerly DES 12277) (01/03)

WISCONSIN FAMILY MEDICAID, BADGERCARE, AND FAMILY PLANNING WAIVER INSTRUCTIONS FOR APPLICATION AND REVIEW

This application is to be used by families with children under age 19 and pregnant women who are applying for Wisconsin Medicaid or BadgerCare, and for single women between the ages of 15 and 44 who are applying for the Family Planning Waiver. This is not an application for food stamps, child care, or W-2. If you are interested in applying for these assistance programs you must contact your local county/tribal social or human services department, or your W-2 agency. These programs provide persons or families help with the costs of food, the costs of child care, or finding a job as part of W-2.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county/tribal social or human services department. For other questions regarding Wisconsin Medicaid or BadgerCare, please call Medicaid Recipient Services at 1-800-362-3002. Information is also available on the Department of Health and Family Services Web site at: ***HTTP://WWW.DHFS.STATE.WI.US/MEDICAID/***.

If you have a disability and need to access the instructions and application in an alternate format, or need it translated to another language, please contact (608) 266-3356 or (608) 266-2555 TTY (toll free). All translation services and translated information are free of charge.

HOW TO USE THIS FORM

1. Read instructions completely, before completing application.

2. Print clearly. Use blue or black ink.

3. Fill out the application completely. Answer all the questions. There may be a delay in Medicaid, BadgerCare, or Family Planning Waiver benefits if the application is not complete. If your application is not complete or you requested retroactive eligibility your county/tribal social or human services department will contact you for more information.

4. Do not write in the shaded sections.

5. Enter information about all the people that live in your household. If you need more space add a second sheet.

6. If you are pregnant, please include with your application a signed and dated note from your doctor or another health care professional saying that you are pregnant and identifying your expected due date.

7. You may authorize a representative to apply for you. Complete and send the Authorized Representative form included in these instructions with your application. This form authorizes a representative to complete and sign the application for you. A legal guardian, conservator, or power of attorney/durable power of attorney may apply for an individual without separate authorization by the individual.

IMPORTANT INFORMATION

The following is important information regarding Wisconsin Medicaid/BadgerCare eligibility.

- Your application date is the date your application is received by your county/tribal social or human services department. The application must include at least your name, address, and signature. A decision regarding your eligibility for Medicaid, BadgerCare or Family Planning Waiver will be mailed to you within 30 days of the application date. Unsigned forms will not be processed and will be returned.

  It is important to apply as soon as possible. Eligibility for benefits is based on your application date. If you are eligible, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those

months. If you are interested in help paying for health care for any of the three months prior to your application date (backdating), make sure you checked the "Yes" box on the application where the backdating question is asked.

There is no backdating for BadgerCare or Family Planning Waiver. Eligibility for these programs can begin no earlier than the first of the month in which you apply.

- Your rights and responsibilities are provided in the *Wisconsin Medicaid Program – Eligibility and Benefits* brochure (PHC 10025). If you do not have a brochure, you may obtain one at your local county/tribal social or human services department or by calling Medicaid Recipient Services at 1-800-362-3002. If you have any questions about your rights and responsibilities contact your local county/tribal social or human services department or Medicaid Recipient Services at 1-800-362-3002.

- If you are found eligible for Medicaid, BadgerCare, or the Family Planning Waiver you will need to complete a review every 12 months to determine eligibility. Changes in your income or household composition need to be reported to your county/tribal social or human services department within 10 days of occurrence. For the Family Planning Waiver program, only changes in household composition and residency need to be reported within 10 days.

SECTION I – Client Information

Do you need help paying for health care for any of the previous three months?
Check "Yes" if you need help paying for health care received during any of the previous three months. Check "No" if you do not need help paying for health care received during the previous three months. If you have checked "Yes", additional information will be necessary to process your application. Your local county/tribal social or human services department will be contacting you. **Remember:** If applying for BadgerCare or the Family Planning Waiver you cannot have your eligibility backdated for the previous three months.

Is there anyone blind, disabled or incapacitated in your household?
Check "Yes" if anyone in your household is blind, incapacitated or has a disability. Check "No" if no one in your household is blind, incapacitated or has a disability. If you check "Yes" more information is necessary and you will need to complete the Elderly, Blind and Disabled Medicaid Application. Your local county/tribal social or human services department will contact you.

Check the language that you want notices printed in.
Check "English" if you would like your notices printed in English. Check "Spanish" if you would like your notices printed in Spanish. If you need assistance with translating any notice you receive into another language other than English or Spanish, contact your local county/tribal social or human services department.

Language spoken in the home.
Enter the language spoken most often in your home.

Case Number
Do not fill in shaded area.

Date Received
Do not fill in shaded area.

Name of Person Applying for Aid
Enter your last name, first name and middle initial of the person applying for Medicaid, BadgerCare, or the Family Planning Waiver benefits.

Telephone Number
Enter your 10-digit telephone number (include area code, for example (608) 292-4021).

We assume your children attend school full time. If not indicate here.
List the first and last names of your children, who are under 18 years of age, who do <u>not</u> attend school full time.

Address
Enter your address, street, city, state and zip code.

Mailing Address
Enter the mailing address where you would like information sent regarding your Medicaid/BadgerCare eligibility. This may be your current address or the current address of your authorized representative. You may use the mailing address as an alternate address of where you would like to receive confidential information regarding the Family Planning Waiver.

SECTION II – General Information

Eligibility for Medicaid/BadgerCare will be based on family members living in your household. Complete this section of the application for all family members living in your household.

Name
Enter the last name, first name and middle initial of all family members living in your household. This may include yourself, your spouse, father, mother, children or stepchildren, etc. If you are under 18 years of age applying only for the Family Planning Waiver for yourself and do not have a spouse or child, only enter information about yourself.

Applying for Medicaid?
For each member of your household check "Yes" if that member is requesting Medicaid/BadgerCare. Check "No" for each member of your household who is not requesting Medicaid/BadgerCare.

Applying for the Family Planning Waiver?
The Family Planning Waiver provides limited Medicaid benefits in the form of family planning services for women between the ages of 15 and 44. Women applying for the Family Planning Waiver do not need to apply for Medicaid/BadgerCare, but it would be in your best interest to apply because Medicaid provides access to full benefits.

Check "Yes" if any woman in your household, between the ages of 15 and 44, is applying for the Family Planning Waiver. Check "No" for any woman in your household, between the ages of 15 and 44, who is not applying for the Family Planning Waiver.

If you do not check "Yes" or "No" the application will be processed assuming "No" for those women between the ages of 15 and 44.

Social Security Number
Enter a Social Security Number (SSN) for all members of your household who are applying for Medicaid, BadgerCare or the Family Planing Waiver. If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver you do not need to provide SSN information for that person.

Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

If you are applying only for emergency services because of your immigration status; you do not need to provide SSN information.

SSN information will be used for administration of the Medicaid program. Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration (SSA) and the Department of Workforce Development. In addition, the Department will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the Immigration and Naturalization Service (INS).

Date of Birth
Enter the birth date of all members of your household. When entering the birth date, use the number for the month, day and year. (Example: If your birth date is February 23, 1970, enter 02/23/70.)

Gender
Circle "M" for each male member of your household. Circle "F" for each female member of your household.

Marital Status
Enter the code in the space provided that best describes each household member's marital status.

- A = Annulled
- D = Divorced
- LS = Legally Separated
- M = Married
- S = Separated
- N = Never Married
- W = Widowed

Are you a U.S. Citizen?
Check "Yes" for each member of your household that is a U.S. citizen. Check "No" for each member of your household that is not a U.S. citizen. If you checked "No" for any household member applying for Medicaid, BadgerCare or the Family Planning Waiver, submit a copy of both sides of the immigration documentation with this application. Information may be submitted to the INS for verification for those applying for these programs.

If someone in your household is not applying for Medicaid, BadgerCare or the Family Planning Waiver you do not need to provide proof of immigration status for that person.

What is your race or ethnic background? (Optional)
Enter the code or codes that best describe the race or ethnic background of each member of your household. This information is voluntary and will not be used to determine eligibility.

- A = Asian
- B = Black
- H = Hispanic origin
- I = American Indian/Eskimo
- P = Native Hawaiian or Pacific Islander
- S = Southeast Asian
- W = White

Relationship to Applicant
Enter the relationship to the applicant of each person listed.

SECTION III – Absent Parent Information (Use a separate sheet of paper if additional space is needed.)

A Medicaid/BadgerCare eligibility requirement is cooperation with identifying parents who are absent from the home. Complete this section as accurately as you can for each parent absent from the home. If there is a reason you do not want to provide information for an absent parent, leave this section blank.

If you are a woman, between the ages of 15 and 18 and applying only for the Family Planning Waiver for yourself, do not complete Section III.

If this section is left blank, you will be contacted by your local/tribal social or human service department for additional information, unless you are a woman between the ages of 15 and 18 applying for the Family Planning Waiver.

Do any children have a natural or adoptive mother or father who is not living at home?
Check "Yes" if any of the children living in your household have either a natural or adoptive parent who is not living in the home. If you checked "Yes", complete all of Section III.

Check "No" if the children living in the home have both natural or adoptive parents living in the home. If you checked "No", skip to Section IV.

Name
Enter the last name, first name and middle initial of any parent who is absent from the home.

Social Security Number
Enter the Social Security Number (SSN) of the absent parent, if you know it. If this field is left blank, you may be contacted by your local/tribal social or human service department for additional information.

Date of Birth
Enter the birth date of the absent parent, if it is known. When entering the birth date, use the number for the month, day and year. (Example: If the birth date is February 23, 1970, enter 02/23/70 in the space provided.)

Name(s) of Child(ren)
Enter the last name, first name and middle initial of the child(ren) of this absent parent.

Relationship to Child
Check "Mother" or "Father" to indicate the absent parent's relationship to the children listed.

Reason for Parent's Absence
List the reason why the parent does not live in the household. (For example, divorced, separated, not married, unable to locate.)

Date Parent Left the Household
Enter the date that the absent parent left the household, if known. When entering the date, use the number of the month, day and year. (Example: If the date the parent left the household is March 3, 1999, enter 03/03/99 in the space provided.)

Date of Last Contact with Parent
Enter the date of last contact with the absent parent.

Court Order of Divorce or Paternity
If there is a court order of divorce or paternity, enter the case number, county, and state for the order that was issued.

SECTION IV – Employment (Use a separate sheet of paper if additional space is needed.)

Medicaid, BadgerCare and the Family Planning Wavier eligibility will be based on your total family income, except if you are a woman between the ages 15 and 18, applying for only the Family Planning Waiver.

Enter the expected gross monthly earnings for the current month and next month for each member of your household. If you are a woman, between the ages of 15 and 18, applying for only the Family Planning Waiver your parents' and sibling income is not counted.

Are you or any household member working?
Check "Yes" if any member of your household is working and complete the rest of the Section IV. Check "No" if no one in your household is working, and skip to Section VI.

Is anyone listed in Section IV a migrant worker?
Check "Yes" if any member of your household is a migrant worker and complete the rest of Section IV. Check "No" if no one in your household is a migrant worker.

Name Working Person
Enter the last and first name of each member of your household that is employed.

Employer's Name, Address and Telephone Number
Enter the employer's name, address and telephone number for each member of your household who is employed.

Date Employment Began
Enter the beginning date of employment for each member of your household who is employed. When entering the date, use the number of the month, day and year. (Example: If the date that employment began is May 2, 2000, enter 05/02/00 in the space provided.)

Gross Monthly Earnings Expected this Month
Enter the expected monthly gross earnings (before taxes and deductions) for this month for each member in your household who is employed.

Gross Monthly Earnings Expected Next Month
Enter the expected monthly gross earnings (before taxes and deductions) for next month for each member in your household who is employed.

SECTION V – Self-Employment (Add a second sheet of paper if more than one person is self-employed.)

Are you or any household member self-employed?
Check "Yes" if you or any member of your household is self-employed. If you checked "Yes" complete the rest of Section V. List amounts you reported to the IRS on your tax forms. If you did not file taxes last year, leave the net annual income and depreciation boxes blank. Your county/tribal agency will contact you for more information.

If no one in your household is self-employed, check "No" and continue on to Section VI.

Self-Employed Person
Enter the last name, first name and middle initial of each person in the household who is self-employed.

Business Name and Address
Enter the name and address of the business for each person in the household who is self-employed.

Type of Business
Enter the type of business for each person in the household who is self-employed.

Net Annual Income
Enter the net annual income for each person in the household who is self-employed. List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your county/tribal social or human services department will contact you for more information.

Depreciation Amount Claimed
List the amounts reported to the IRS on your tax forms. If you did not file taxes last year, leave this box blank. Your county/tribal social or human services department will contact you for more information.

Income you Expect to Earn this Year
Enter the amount of gross annual income (before taxes and deductions) for each person in the household who is self-employed.

SECTION VI – Unearned Income

Other Type of Income/YES/NO
Check "Yes" if anyone in your household receives unearned income. Check "No" if those in your household do not receive unearned income. If you answer "Yes" complete Section VI for each income type.

Name
Enter the name of the person for the income types that were checked "Yes".

Gross Monthly Amount
Enter the gross monthly amount received for each income type for the ones checked "Yes".

SECTION VII – Insurance (Use a separate sheet of paper if additional space is needed.)

Does any person have medical/health insurance now, or in the previous three months?
Check "Yes" if any person in the household has medical/health insurance now, or had medical/health insurance in the previous three months. Check "No" if no one in the household has medical/health insurance now or has had medical/health insurance in the previous three months.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Name/Address of Insurance Company
Enter the name and address of the insurance company.

Policyholder Name
Enter the first and last name of the policyholder.

Policy Number
Enter the policy number.

Date Began
Enter the date (mm/dd/yy) the policy began. (For example, if the date is February 2, 2001, enter 02/02/01 in the space provided.)

Date End
Enter the date (mm/dd/yy) the policy ended.

Who is covered under the policy?
Enter the first and last name of those persons covered under the policy.

SECTION VIII – Child Care (Use a separate sheet if additional space is needed.)

Does anyone in the household pay for child care or adult care so they can work, look for work, go to school or receive training?
Check "Yes" if someone in your household pays for child care or adult care so they can work, look for work, go to school or receive training. Check "No" if no one in your household pays for child care or adult care.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Who pays for the care?
Enter the name of the person in the household who pays for child care or adult care.

Who do you pay?
Enter the name of the person who receives payment for child care or adult care.

Does s/he live in your household?
Check "Yes" if the person you pay for child care or adult care lives in your household. Check "No" if the person you pay for child care or adult care does not live in your household.

Who is the care for?
Enter the name of the person for whom the child or adult care payment is made.

Monthly Amount
Enter the monthly amount that is paid for child care or adult care.

SECTION IX – Child Support

Does anyone pay child support?
Check "Yes" if someone in your household pays child support. Check "No" if no one in your household pays child support.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Who pays the child support?
Enter the name of the person in your household who pays child support.

Who receives the child support payments?
Enter the name of the person who receives the child support payment. (This should be the name of the absent parent.)

Monthly Amount
Enter the monthly amount that is paid or received for child support.

SECTION X - Pregnancy

Are any members of your household pregnant?
Check "Yes" if a woman in your household is pregnant. Check "No" if there are no pregnant women in your household.

If you checked "Yes" answer the questions to the right of the YES/NO box.

Name of Pregnant Woman
Enter the first and last name of the pregnant woman in your household.

Due Date
Enter the due date of the pregnant woman in your household. (For example, if the due date is April 3, 2003 you would enter 04/03/03 in the space provided.) You will need to provide verification from a medical professional of your pregnancy and the due date to your county/tribal social or human services department.

Multiple births expected?
Enter "Yes" if multiple births are expected. Enter "No" if multiple births are not expected.

Number of Babies Expected?
Enter the number of babies that is expected.

SECTION XI – Rights and Responsibilities

Your signature on the application means that you understand and acknowledge that the county/tribal social or human services department, W-2 agency and the state Department of Health and Family Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program authorized under Wisconsin law.

Any person, including any financial institution, credit reporting agency, employer, or educational institution, is authorized to release this information, according to Wisconsin Statute s. 49.22(2m)(a): "The department may request from any person in this state information it determines appropriate and necessary for the administration of this section, ss.49.141 to 49.161, 49.19, 49.46, 49.468 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Unless access to the information is prohibited or restricted by law, or unless the person has good cause, as determined by the department in accordance with federal law and regulations, for refusing to cooperate, the person shall make a good faith effort to provide this information within 7 days after receiving a request under this paragraph. Except as provided in subs. (2p) and (2r) and subject to sub.(12), the department or the county child support agency under s.59.53(5) may disclose information obtained under this paragraph only in the administration of this section, ss.49.141 to 49.161, 49.19, 49.46 and 49.47 and programs carrying out the purposes of 7 USC 2011 to 2029. Employees of the department or a county child support agency under s.59.53(5) are subject to s.49.83."

You have the right to appeal any action taken concerning your Medicaid, BadgerCare, or Family Planning Waiver application or on going benefits that you do not agree with by requesting a Fair Hearing. You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

You may also contact your local county/tribal social or human services department and ask for a Fair Hearing verbally or in writing.

The Department of Health and Family Services (DHFS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-3465 (voice) or (608) 266-2555 (TTY).

To file a complaint of discrimination by contacting either the:

- Wisconsin Department of Health and Family Services (DHFS)
  Affirmative Action and Civil Rights Compliance Office
  1 W. Wilson, Room 555
  Madison, WI 53707-7850
  Telephone: (608) 266-3972 (Voice); (608) 266-5555 (TTY)
  Fax: (608) 267-2147

- U.S. Department of Health and Human Services
  Office for Civil Rights – Region V
  233 N. Michigan Avenue
  Suite 240
  Chicago, IL 60601
  Telephone: (312) 886-5077 (voice) or (312) 353-5693 (TTY)

CHECKLIST

☐ Is the application complete?

☐ If you are not a U.S. citizen, did you include a copy of both sides of your immigration status documents?

☐ If you are pregnant, did you include a signed and dated note from a doctor or other health care professional saying that you are pregnant and stating the due date?

☐ Did you read the Rights and Responsibilities Section?

☐ Did you sign and date the application form?

☐ Did you include the Authorized Representative Form if you are acting on behalf of an applicant?

Send the completed application to your local county/tribal social or human services department, W-2 agency, or Medicaid outstation site. Addresses for county/tribal agencies can be found at: http://www.dhfs.state.wi.us/Medicaid1/contacts/recipient-contacts.htm or by contacting Medicaid Recipient Services at 1-800-362-3002.

OTHER PROGRAM INFORMATION

If you are interested in services for veterans, call 1-800-947-8347 (WIS-VETS), or contact your county Veteran Service Officer.

For information about the Women, Infants, and Children (WIC) Nutrition Program, call 1-800-722-2295.

For information about services for women, children and families, contact the Wisconsin Maternal Child Health Hotline at 1-800-722-2295.